STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Golden Living Center Franklin (IIDR)
Survey Exit Date: October 6, 2011

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) written review conducted by Administrative Law Judge Kathleen D. Sheehy on March 8, 2012. The record of the Office of Administrative Hearings (OAH) closed on that date.

Chris Campbell, IIDR Coordinator, Licensing and Certification Program, Division of Compliance Monitoring (Division), P.O. Box 64900, St. Paul, MN 55164-0900, submitted materials for the Division.

Sheila Honl, Director of Nursing Services, Golden Living Center Franklin (Facility), 900 East Third Street, Franklin, MN 55333, submitted materials for the Facility.

FINDINGS OF FACT

1. On October 6, 2011, the Division issued a Statement of Deficiencies to the facility, citing Tag F 248,[1] Tag F 250,[2] and F 319[3] at a scope and severity level of D (isolated, with potential for more than minimal harm that is not immediate jeopardy). The facility's allegedly deficient practices pertain to four different residents.

Tag F 248—Failure to Provide Ongoing Program of Activities

2. Resident # 19 is a 99-year-old woman with dementia and macular degeneration. In the earlier years of her life, she had been a chemistry teacher, member of the school board, and an active church goer. She was admitted to the Facility in July 2008. At the time of the survey, the Resident had moderate hearing

[1] This tag alleges a violation of 42 C.F.R. § 483.15(f), failure to provide an ongoing program of activities to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of each resident.
[2] This tag alleges a violation of 42 C.F.R. § 483.15(g), failure to provide medically-related social services to attain or maintain the highest physical, mental, and psychosocial well-being of each resident.
[3] This tag alleges a violation of 42 C.F.R. § 483.25(f), failure to ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

difficulty with the use of hearing aids, and her vision was severely impaired despite the use of glasses. She required extensive assistance from staff for all activities of daily living. She had a short attention span and had difficulty staying engaged in group activities. She tended to sleep for long periods of time and then go through periods of restlessness.[4]

3. The Facility conducted a quarterly activity assessment of the Resident on September 7, 2011. Because the Resident's speech is difficult to understand, her family provided the information about her activity preferences. A number of activities were identified on the MDS as being important to the Resident, but she was no longer able to do them. These activities included reading books, newspapers, and magazines; being around animals; doing things with groups of people; getting outside during good weather; and participating in religious services or practices. Activities identified as unimportant were listening to music and keeping up with the news.[5] At the time, the Resident was participating in a Day Enrichment program two times per week.[6]

4. The assessment concluded that the Resident would attend a Day Enrichment program one time per week for five to 30 minutes, as tolerated. It also provided that the Resident would sometimes attend church with her daughter at the facility and that the Resident's family was very supportive and visited almost daily.[7]

5. The care plan for Resident # 19 described her difficulty starting and staying involved in recreational activities, as evidenced by her short attention span, difficulty following cues, dementia, and macular degeneration. Her goal was stated as follows: "I would like to continue to participate in activities of interest with extensive assist from staff through next visit." The interventions were described as follows:

> •If I become less involved in group activities, please do 1:1 activities with me that I'll enjoy that may include prayers, rosary, painting my fingernails, reading my mail to me, stories, newspaper or magazine articles.
>
> •Please help me participate in my favorite activities at my highest level which include attending church services, getting my hair done, visiting with others and my family.
>
> •Reduce distractions in the area where I am participating in activities.
>
> •My life's simple pleasure[s] are prayers and the rosary.[8]

6. During the survey, the activity director advised the surveyor that Resident #19 "receives one 1:1 weekly, and others on an as needed 1:1 basis." The Facility's activity documentation reflects that the 1:1 visits usually lasted ten to 15 minutes and

[4] Facility documentation, progress note 9/9/2011; Ex. E-14 (Form 2567).
[5] Facility documentation, MDS 9/7/2011.
[6] Ex. J-20.
[7] Facility documentation, progress note 9/9/2011.
[8] Facility documentation, plan of care print date 9/22/2011; Ex. J-14.

occurred sometimes weekly, sometimes bi-weekly, and sometimes every three weeks.[9] The surveyor concluded that the facility had failed to ensure that a comprehensive assessment had been completed because it did not identify "life long interests, life roles, strengths, needs, or activity pursuit patterns or preferences" and did not adequately describe the Resident's areas of interest.[10]

Tag F 250—Failure to Provide Medically Related Social Services

7. Resident #30 is a 69-year-old man with diagnoses of mild mental retardation, Parkinson's disease, and chronic undifferentiated schizophrenia. He had long-term and short-term memory concerns and required assistance with all activities of daily living.

8. Before Resident #30 was admitted to the Facility in the spring of 2009, he had a Level II Preadmission Screening Report for Persons with Mental Illness. The assessment indicated that the Resident had a documented mental illness, needed specialized services, and met the criteria for care in a nursing facility. It further provided that the County of Financial Responsibility (Brown County) would provide or arrange for (a) on-going psychiatric assessment/reviews, and (b) adult mental health case management services through Brown County Family Services.[11] A summary of the diagnostic findings further provided that the Resident needed community-based specialized services.[12]

9. The Resident's care plan provided for strategies to address or prevent behaviors, but the only mental health services identified were "Please refer me to my psychiatrist as needed."[13] There is no reference in the care plan or in the Resident's medical record to any community-based therapy or psychiatric services received after his admission.[14]

10. The Resident saw a psychiatrist who performed rounds at the Facility three times in 2009, six times in 2010, and three times in 2011, for medication management.[15]

11. Resident #52 is a 48-year-old woman who was admitted to a locked unit at the Facility in July 2011. She had cirrhosis and dementia resulting from alcohol abuse and had eloped from a foster care placement.[16] At the time of admission the Resident's

[9] Ex. J-22 to J-30.
[10] Ex. E-14.
[11] Facility documentation, Evaluative Report (Level II Pre-admission Screening); Ex. K-2 through K-4.
[12] Facility documentation, Summary of Diagnostic Findings; Ex. K-5.
[13] Ex. K-38.
[14] Ex. E-17.
[15] Ex. E-17; Ex. K-15 through K-18.
[16] Ex. L-1 through L-4.

guardian was her brother, who had been appointed on an emergency basis in June 2011 to act as her guardian and conservator of her estate.[17]

12. At the time of admission, the Facility assessed her discharge potential as "Possible transition to secure ALF [assisted living facility]/CD tx [chemical dependency treatment]."[18] The social worker's admission note provided "[a]s appropriate will work [with] guardian on alternate placement."[19]

13. The Resident was angry and unhappy about being placed in the Facility. She was tearful, had a poor appetite, and repeatedly verbalized her need to be with her husband, although he was in the process of obtaining a divorce from her, and they had not lived together for some time. She had a limited support system based on her long-term abuse of alcohol and manipulation of others.[20]

14. In a care conference on July 28, 2011, the team discussed her depressed mood and poor appetite related to placement at the Facility, as well as her verbal outbursts, threats, and refusal of medications, meals, and bathing. The social worker noted "Family working with County case manager per plans for [discharge] and or alternate placement options."[21]

15. The Resident's care plan provided that her discharge goal was "I will be able to transfer to a different facility when placement is located and guardian agrees." The interventions were described as:

> •Educate me/my guardian and my care giver about my diagnosis, behaviors and needs.
>
> •Help me arrange, as needed for rehab/care services I may need once I leave.
>
> •Help make any transportation arrangements I may need per request of my guardian.
>
> •Assist with coordination of services upon discharge as needed.
>
> •Please help me plan for community integration, if appropriate.[22]

16. The Resident contested her brother's appointment as guardian in the district court proceeding. A series of hearings was held in August, September, and October 2011. Eventually, a different guardian was appointed.[23]

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[17] Facility documentation, Fourth Order Extending Emergency Appointment of Guardian of the Person and Conservator of the Estate (Nov. 1, 2011).
[18] Facility documentation, Psychosocial History/Assessment (July 13, 2011).
[19] Facility documentation, Social Work Admission Note (July 6, 2011).
[20] Facility documentation, Psychosocial History (July 13, 2011).
[21] Facility documentation, Care Conference Summary (July 28, 2011).
[22] Facility documentation, Care plan (print date July 28, 2011).

17. On September 20, 2011, the Facility's social worker contacted the County to determine whether there was a plan for chemical dependency treatment or a transition plan in place for the Resident. The social worker followed up one week later but again received no response.[24]

18. When interviewed by a surveyor on October 3, 2011, the Resident stated she had no idea what was going to happen to her, and she did not understand why she was locked up with a "bunch of old people" in the nursing home.[25]

19. The Facility's social worker believed that development of a discharge plan was the responsibility of the guardian and the county case worker. She was not aware of what options, if any, had been discussed for the Resident. No discharge planning had begun at the time of the survey, even though the Resident's indefinite placement in a locked unit of a nursing home was inappropriate to address her needs.[26]

Tag F 319—Failure to Ensure that a Resident Who Displays Adjustment Difficulty Receives Appropriate Treatment and Services

20. Resident #44 was a 91-year-old man who was admitted to the Facility on August 9, 2011. He had severe cognitive impairment and suffered from mild depression. The Resident's wife, who had been his primary caretaker for many years, was terminally ill and expected to live only a short time. She was admitted to hospice care in the Facility at the same time. She continued to provide some assistance with the Resident's care after admission.

21. At the time of admission, the Facility assessed the Resident's cognitive loss and dementia, noting his short-term and long-term memory loss. It identified as confounding factors his previous residence in an apartment with his wife, who directed and supervised his daily activities. It identified as an area of strength the Resident's ready acceptance of cues and re-direction and demonstration of a pleasant disposition.[27] The assessment of his psychosocial well-being identified the Resident's mood as having little interest or pleasure in doing things, but indicated the Resident was able to readily verbalize his concerns and needs. The Facility referred him to the hospice for grief support.[28] His behavioral symptoms (refusal of care and wandering) did not merit referral to another discipline at that time.[29]

22. The Resident's wife died on September 8, 2011.

23. Beginning the next day and continuing for the next month, the Resident's mood and behavior began deteriorating markedly. He attempted to elope from the

[23] Facility documentation, Fourth Order Extending Emergency Appointment of Guardian of the Person and Conservator of the Estate (Nov. 1, 2011).
[24] Ex. L-6.
[25] Ex. E-18.
[26] Ex. E-18.
[27] Ex. M-44.
[28] Ex. M-49.
[29] Ex. M-52.

Facility multiple times, telling staff he was going home and threatening to hit staff members. He tried to keep staff members from entering his room by holding the door closed. He resisted efforts to help him get dressed and began to refuse taking his medications. He stated his intention to leave the Facility, get two guns, and shoot himself or others who got in his way. He refused to eat and began mixing his food together and dumping it onto the table. He refused to bathe or shower or to have dressings on a leg wound changed.[30] For the most part, the Resident resisted all staff efforts to redirect him.

24. On September 27, 2011, the Facility contacted a psychiatrist who saw residents at the Facility, describing Resident #44's refusal to take medications, his attempts to leave the facility, and his depression. The psychiatrist indicated the Facility should "hold" the Resident.[31]

25. On October 5, 2011, the Facility transferred the Resident to a hospital because of his depression, anger, refusal to eat or drink, refusal of medications, refusal to bathe or change clothing, threats to shoot himself and others, and refusal to allow dressing changes.[32] He returned to the Facility on October 14, 2011, and he passed away on October 27, 2011.

26. At the time of the survey, the Resident's care plan identified as one problem his "alteration in thought process and psychosocial well-being related to diagnosis of malaise and fatigue, new placement and terminal status of wife." The interventions described a variety of ways Facility staff could support him. Other problems identified were anticipatory grief related to wife's cancer diagnosis and hospice support, with interventions including offering of staff support, encourage verbalizing of fears and concerns, keep family informed, and provide religious/spiritual support as needed; and the alteration in his behavior related to "diagnosis of malaise and fatigue evidenced by rejection of care and wandering. Resident is new to the environment." The care plan contained the following goal: "My behavior will stop with staff intervention and or re-direction." The plan contained a number of interventions aimed at re-directing his behavior and further provided "Please refer me to a psychiatrist as needed."

27. Although the Facility contacted the psychiatrist to seek a prescription for an antidepressant medication on October 4, 2011, it made no effort to determine whether referral to therapy or other mental health services would assist the Resident with the many transitions in his life before he was hospitalized.

Based upon the documents submitted and the arguments made, and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

[30] Ex. E-44 through E-49.
[31] Facility documentation of physician contact (9/27/11).
[32] Ex. E-48.

RECOMMENDED DECISION

The citation with regard to Tags F 248, F 250, and F 319 are supported by the facts and should be AFFIRMED as to scope and severity.

Dated: March 19, 2012 s/Kathleen D. Sheehy

KATHLEEN D. SHEEHY
Administrative Law Judge

NOTICE

Under Minn. Stat. § 144A.10, subd.16 (d)(6), this recommended decision is not binding on the Commissioner of Health. Under Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

Tag F 248

This is a quality of life citation. The regulation requires a facility to care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.[33]

According to the State Operations Manual (SOM), "activities" refer to any endeavor, other than routine activities of daily living (ADL), in which a resident participates that is intended to enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence. ADL-related activities, such as manicures/pedicures, hair styling, and makeovers, may be considered part of an activities program. During the assessment process, the facility should obtain sufficient detailed information to determine what activities the resident prefers and what adaptations, if any, are needed. Information obtained during the assessment process should be used to identify activity goals in the care plan. Activity goals identified in the care plan should be based on measurable objectives and focused on desired outcomes. Activities do not have to be formal activities provided by activities staff members; other staff, volunteers, other residents, or family members may provide them.[34]

[33] 42 C.F.R. § 483.15(f).
[34] Ex. F-1 through F-4.

A facility is in compliance with this requirement if it has recognized and assessed for preferences, choices, specific conditions, causes and/or problems, needs and behaviors; defined and implemented activities in accordance with resident needs and goals; monitored and evaluated the resident's response; and revised the approaches as appropriate. A facility is not in compliance if planned activities were not conducted or designed to meet the resident's care plan.[35]

In this case, the Facility appears to have appropriately assessed Resident #19's interests in various informal activities given her limitations, and those activities are reflected in the care plan. Contrary to some of the findings in the 2567, the assessment did adequately describe the Resident's activities of interest; the problem is that there is no apparent plan or program for ensuring how frequently those activities will take place. From the documentation provided, the 1:1 sessions were brief and sometimes took place weekly, but often were two or three weeks apart. The Administrative Law Judge cannot conclude from the record that there was a program of planned activities in place. This citation should be affirmed.

Tag F 250

This tag is also a quality of life citation. The regulation requires that a facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.[36] According to the SOM, the facility must aggressively identify the need for medically-related social services and pursue the provision of these services by the appropriate discipline. The services might include making referrals and obtaining services from outside entities, discharge planning, providing or arranging needed counseling services, and using the assessment and care planning process to identify and seek ways to support a resident's individual needs.[37] Social services should be provided in response to conditions such as lack of an effective family support system; behavioral symptoms; the presence of a chronic disabling medical or psychological condition; alcohol abuse; need for emotional support; or changes in family relationships, living relationships, and/or a resident's condition or functioning.[38]

The two residents in question both had indicators of need for medically-related social services. The pre-admission medical record for Resident #30 unequivocally described both a need for and County approval of payment for community-based therapeutic services. The Facility should have followed up to pursue the provision of these services or to obtain some verification that they were not necessary. Resident #52 was clearly a difficult person to deal with, and the dispute over guardianship did protract matters. But the Facility had an independent obligation to ensure that appropriate discharge planning was being performed and that the Resident did not remain too long in a placement that was so distressing to her. The Administrative Law Judge accordingly concludes that this citation should be affirmed.

[35] Ex. F-19 and F-20.
[36] 42 C.F.R. § 483.15(g).
[37] Ex. G-1 to G-2.
[38] Ex. G-3 to G-4.

Tag F 319

This tag is a quality of care citation. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on the comprehensive assessment of a resident, the facility must ensure that (1) a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem, and (2) a resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.[39] According to the SOM, mental and psychosocial adjustment difficulties are characterized primarily by an overwhelming sense of loss of one's capabilities, of family and friends, of the ability to continue to pursue activities and hobbies, and of one's possessions. A resident with a mental adjustment disorder will have a sad or anxious mood, or a behavioral symptom such as aggression.[40]

The Facility contends that the Resident's increasingly complicated behavior was related to his advancing dementia and medical decline and not to the loss of his wife. The record reflects, however, that the Facility assessed the Resident in August 2011 as having a pleasant disposition, being easy to re-direct, and able to verbalize his concerns and needs. The assessment also properly recognized that the Resident was at risk for adjustment difficulties given the change in environment, the anticipated loss of his wife, and his own malaise and fatigue, and the assessment provided that referrals would be made as appropriate. But the Resident's personality and behavior changed dramatically for the worse almost immediately after the death of his wife, and no referrals were made for any additional services. There is insufficient evidence in the record to support the proposition that the Resident's pattern of decreased social interaction and increased withdrawn, angry, or depressive behaviors was the unavoidable result of the Resident's clinical condition, as opposed to an emotional reaction to the many changes in his life that might have been mitigated with appropriate treatment and services. The Administrative Law Judge concludes the citation should be affirmed.

K.D.S.

[39] 42 C.F.F. § 483.25(f).
[40] Ex. H-1 and H-2.